No. 08-1515

In the Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
PETITIONER

v.

CITY AND COUNTY OF SAN FRANCISCO, CALIFORNIA,
ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a), preempts the provisions of San Francisco's Health Care Security Ordinance, S.F. Cal. Admin. Code §§ 14.1-14.8 (2007), mandating that covered employers in San Francisco spend a specified amount for health care benefits for their covered employees.

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INTEREST OF THE UNITED STATES

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. In 2006, respondent City and County of San Francisco (City) enacted the Health Care Security Ordinance (HCSO), S.F. Cal. Admin. Code. §§ 14.1-14.8, to provide health care for its uninsured residents. The HCSO has two primary components: the Health Access Plan (HAP) and employer spending requirements. Pet. App. 3a.

The HAP is a public health care program, operated by the City, which provides health care through a network of public and private providers. The HAP is primarily funded by city taxes but also receives part of its funding from employer payments under the HCSO and from payments by participating individuals. All San Francisco residents who lack health insurance and meet age and income requirements are eligible to participate in the HAP whether or not they are employed. Participants in the HAP pay income-based fees, and employees who are covered by the employer spending provisions of the HCSO may enroll at a significantly reduced rate. Pet. App. 3a, 8a, 113a-115a.

The employer spending requirements mandate that covered employers make minimum "health care expenditures" to or on behalf of covered employees each calendar quarter. "Covered employers" are for-profit employers engaged in business within the City that have an average of at least 20 paid employees during the quarter and non-profit employers that have an average of at least 50 paid employees. "Covered employees" are individuals who work within the City for a certain minimum number of hours each week, have worked for the employer for at least 90 days, and are not otherwise excluded from coverage. Pet. App. 5a-6a, 107a-109a, 127a-128a, 130a-135a.

The required expenditures are determined by multiplying the total number of hours worked by each covered employee during the quarter by the applicable "health care expenditure rate." The current rate is either $1.23 or $1.85 per hour, depending on the type and size of the employer, but the rate may increase in future years based on projections from an annual ten-county

survey of health care spending. Pet. App. 6a, 111a, 139a-140a.

The HCSO defines "health care expenditures" as "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." Pet. App. 110a. Eligible "health care expenditures" include but are not limited to (1) contributions on behalf of covered employees to federal health savings accounts or other accounts having substantially the same purpose or effect; (2) reimbursement of expenditures by covered employees for health care services; (3) payments to third parties for the provision of health care services to covered employees; (4) costs incurred in providing direct delivery of health care services to covered employees; and (5) payments to the City to be used on behalf of covered employees (the city-payment option). The City uses funds received under the city-payment option either to fund membership of covered employees in the HAP (if the employees are eligible to participate) or to fund medical reimbursement accounts for the covered employees (if the employees are not eligible). *Id.* at 7a-8a, 110a-111a, 135a-137a.

The HCSO includes a number of recordkeeping requirements to ensure compliance with the health care spending obligations. Employers must keep records of health care expenditures and proof that the required expenditures are made each quarter; they must provide the City with the information necessary to determine employees' eligibility to participate in the HAP or to establish medical reimbursement accounts; and they must notify employees if they are making payments to the

City to satisfy the health care spending requirements. Employers who fail to comply with the spending or recordkeeping requirements may be subject to administrative action, including monetary penalties. Pet. App. 9a, 116a-119a, 142-144a, 149a-154a.

2. a. After the HCSO was enacted, petitioner, a trade association for the City's restaurant industry, filed suit in the United States District Court for the Northern District of California, contending that the HCSO's spending requirements are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a). Subject to certain exceptions not implicated here, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." *Ibid.* Under ERISA, employee benefit plans include "welfare plan[s]," which in turn include "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries" medical care or benefits. 29 U.S.C. 1002(1).

b. The district court granted summary judgment in favor of petitioner. Pet. App. 83a-103a. The court concluded that the HCSO's spending requirements "relate to" ERISA-covered employee benefit plans within the meaning of Section 1144(a). *Id.* at 93a. The court explained that state or local laws "relate to" ERISA plans under that provision if they are "connected with" or "make reference to" ERISA plans. *Id.* at 89a (citing *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court concluded that the HCSO's spending requirements are connected with ERISA plans because they interfere with nationally uniform administration of plans, affect the structure and administration of plans, and mandate the provision of benefits covered by plans.

Id. at 93a-98a. The court also found that the HCSO's spending requirements make unlawful reference to ERISA plans because the vast majority of employers conduct their health care spending through ERISA plans and, in order to enforce the spending requirements, the City will have to ascertain whether and how much employers are paying for health care coverage under their existing ERISA plans. *Id.* at 98a-102a.

3. a. The City, along with several unions that had intervened in the lawsuit, sought a stay of the district court's judgment pending appeal. The district court denied their request, but the court of appeals granted a stay. Pet. App. 3a-4a. In granting the stay, the court of appeals concluded that the City had a strong likelihood of success on the merits of the preemption issue. *Golden Gate Rest. Ass'n* v. *City & County of S.F.*, 512 F.3d 1112, 1114 (9th Cir. 2008).

b. After briefing and argument on the merits, including by the Department of Labor, which argued that ERISA preempts the HCSO's spending requirements, the court of appeals reversed the district court's judgment. Pet. App. 1a-40a. The court first concluded that employers can comply with the spending requirements without creating or changing ERISA plans because they can utilize the city-payment option. *Id.* at 15a-26a. The court rejected the position that the record-keeping, reporting, and payment obligations employers assume when they choose the city-payment option in themselves constitute the creation of an ERISA plan. *Id.* at 16a-23a. The court reasoned that, under the city-payment option, an employer has no responsibility other than to calculate and make the required payments to the City for covered employees and to retain records to show that it has done so. *Id.* at 18a. The court observed that

those administrative obligations are similar to obligations imposed on employers under many federal, state, and local tax laws. *Id.* at 19a. The court similarly concluded that the employers' responsibilities under the city-payment option do not involve sufficient discretion to constitute an "ongoing administrative scheme," which is necessary to qualify as an ERISA plan. *Id.* at 20a (citation omitted).

The court then rejected the proposition that the City's HAP itself is an ERISA plan. Pet. App. 23a-26a.[1] The court observed that the HAP is a government entitlement program, administered by the City and available to City residents regardless of their employment status. *Id.* at 24a. In addition, the court noted, the City, rather than any employer, controls eligibility and coverage decisions and determines the kind and level of benefits. *Id.* at 25a-26a.

The court of appeals also rejected the contention that the HCSO has an impermissible connection with ERISA plans because it interferes with uniform administration of ERISA plans. Pet. App. 26a-32a. The court reasoned that the HCSO does not require any employer to adopt an ERISA plan, to provide specific benefits, or to follow particular rules in administering any ERISA plan that the employer may provide. *Id.* at 29a-31a. The court acknowledged that the HCSO imposes administrative burdens on covered employers, but concluded that those burdens do not impermissibly interfere with plan administration because they exist whether or not an employer has an ERISA plan. *Id.* at 32a.

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[1] Contrary to the court's statement (see Pet. App. 23a-24a), the Department of Labor did not argue that the HAP is itself an ERISA plan. See *id.* at 68a, 77a.

The court of appeals further concluded that the HCSO's spending requirements do not make a forbidden "reference" to ERISA plans because the requirements "can have [their] full force and effect even if no employer in the City has an ERISA plan." Pet. App. 33a. The court noted that an employer's obligations under the HCSO are not measured by the level of benefits provided by an ERISA plan but by the payments that the employer provides either to a plan or to another entity, such as the City. *Id.* at 35a.

Finally, the court of appeals rejected petitioner's contention that the HCSO would be preempted under the analysis adopted by the Fourth Circuit in *Retail Industry Leaders Ass'n* v. *Fielder*, 475 F.3d 180 (2007), which held that a Maryland law mandating a specified level of health care expenditures was preempted. Pet. App. 36a-40a. The court reasoned that, unlike the Maryland law, which gave employers no realistic method of compliance that did not involve an ERISA plan, the HCSO gives employers the city-payment option, which in the court's view does not entail creation of an ERISA plan. The court explained that the city-payment option is a realistic alternative for employers because, unlike the state-payment option under the Maryland law in *Fielder*, the city-payment option gives employers something in return for their payments—health care benefits for their employees. *Id.* at 38a-40a.

c. Petitioner sought rehearing en banc, which the Department of Labor supported in a second amicus brief. See Pet. App. 82a. The court of appeals denied the petition for rehearing, with eight judges dissenting from the denial and one judge concurring and writing to respond to the dissent. *Id.* at 41a-61a.

DISCUSSION

In the court of appeals, the Department of Labor took the position that ERISA preempts the employer health care spending requirements of San Francisco's HCSO because an employer can comply with those requirements only by creating or altering an ERISA plan. After the court of appeals rejected that position, the Department of Labor began to reexamine its views and was considering the promulgation of a regulation clarifying when state and local health care programs result in the creation of ERISA plans. Because that regulation would have been entitled to deference under *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837 (1984), it could have affected the preemption analysis in this case. Since then, however, Congress has enacted comprehensive national health care legislation. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119; Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. Although the federal legislation accommodates state authority over regulation of health insurance, it significantly reduces the potential that state or local governments will choose to enact health care programs like the HCSO and may also affect the question whether such programs are preempted by federal law. For these reasons, the Department of Labor has decided that regulatory action would be premature at this time. For the same reasons that the Department has decided that regulatory action affecting the ERISA preemption issue would be premature, this Court's review of the issue is not warranted at this time. Accordingly, the petition for a writ of certiorari should be denied.

1. Subject to exceptions not applicable here, ERISA preempts "any and all State laws insofar as they may

now or hereafter relate to any employee benefit plan." 29 U.S.C. 1144(a). ERISA defines the term "State" to include subdivisions and agencies of a State, such as the City and County of San Francisco, and defines "State law" to include "rules, regulations, or other State action having the effect of law," 29 U.S.C. 1144(c)(1) and (2), which include ordinances such as the HCSO.

This Court has explained that a law "relate[s] to any employee benefit plan," 29 U.S.C. 1144(a), "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*Travelers*) (citation omitted). But the Court has cautioned against conducting that analysis with an "uncritical literalism," and has stressed that whether a law has a prohibited connection with ERISA plans turns on whether the law interferes with ERISA's core objectives. *Ibid.*

One core objective of ERISA is "to protect * * * the interests of participants * * * and their beneficiaries" in those plans. 29 U.S.C. 1001(b); see 29 U.S.C. 1001(a), 1001a(c), 1001b(c). Another core objective of ERISA, and its preemption provision in particular, "is to provide a uniform regulatory regime over employee benefit plans," *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004), by "establish[ing] the regulation of * * * benefit plans as exclusively a federal concern," *Travelers*, 514 U.S. at 656 (citation and internal quotation marks omitted).

In light of these purposes, this Court has held that a state law has a prohibited connection with ERISA plans if it "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. See, *e.g.*, *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)

(finding state law related to ERISA plans because it mandated provision of specific benefits). State laws are also preempted if they "interfere[] with nationally uniform plan administration." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). Accordingly, ERISA preempts not only state laws that mandate the provision of benefits or require plans to calculate benefit levels differently in different locations, see *Travelers*, 514 U.S. at 657-658, but also state laws that mandate the creation of ERISA plans, see *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 16-17 (1987).

In the court of appeals, the Department of Labor took the position that ERISA preempts the HCSO's employer spending requirements because those requirements both mandate employee benefit structures and interfere with the uniformity of plan administration. See C.A. Br. for the Sec'y of Labor as Amicus Curiae Supporting Appellee and Requesting Affirmance 11-28 (Labor Department Br.); Pet. App. 73a-79a. Central to that position was the Department's conclusion that "all of the options for compliance" with the HCSO "require an employer to create or alter an ERISA plan." Labor Department Br. 11.

The court of appeals did not dispute that, in the case of employers that do not already make health care expenditures at the level mandated by the HCSO's spending requirements, many of the options that the HCSO provides for compliance will involve employers' altering existing ERISA plans or establishing new ones. But the court concluded that "the City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans." Pet. App. 12a. The Department of Labor disagreed with that conclusion, instead

taking the view that when an employer complies with the HCSO's spending requirements by utilizing the city-payment option, the administrative undertakings that the employer must assume constitute the creation of an ERISA-covered plan. *Id.* at 73a-75a; see Labor Department Br. 12-19.

The Department of Labor reasoned that ERISA defines an "employee welfare benefit plan" to include "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits." 29 U.S.C. 1002(1). Accordingly, an employer creates a plan whenever it establishes "an ongoing administrative scheme" for the provision of medical or other covered benefits. *Fort Halifax Packing Co.*, 482 U.S. at 18.

The Department of Labor explained that use of the city-payment option requires an employer to establish an ongoing administrative scheme because, each calendar quarter, the employer must determine which employees are covered by the HCSO's spending requirements and how much is due for those covered employees. In the Department's view, those calculations sometimes require employers to make discretionary decisions, without clear guidance from the HCSO, about who is covered and to what extent. Labor Department Br. 14-15. For that reason, the Department concluded that an employer utilizing the city-payment option "establishes an ERISA-covered plan for its employees, just as an employer establishes an ERISA-covered plan when it provides health benefits for its employees through the purchase of insurance." Pet. App. 74a-75a (citing *Qualls* v. *Blue Cross of Cal., Inc.*, 22 F.3d 839, 843 (9th Cir.

1994) (holding that an employer's purchase of insurance for its employees creates an ERISA-covered plan)). The Department perceived "no relevant difference" between the two scenarios, noting that, "in both cases, the employees receive their benefits from a third party and the program is substantially administered by a third party." *Id.* at 75a.

After the court of appeals' extensive analysis of the HCSO and the court's rejection of the Department of Labor's position, the Department began to reexamine its view. The court of appeals had emphasized the limited amount of discretion exercised by employers under the city-payment option and the fact that the City, rather than the employer, determines the terms, structure, and administration of the program. Pet. App. 20a, 25a-26a. In light of those facts, a difficult question arises about whether an employer's role under the city-payment option more closely resembles the collection and payment of a payroll tax to support a government health program (which does not involve the creation of an ERISA plan) than it does the purchase of health insurance from a private company (which does involve the creation of an ERISA plan). As part of the reconsideration process, the Department stated that it planned to issue a proposed regulation "clarify[ing] the circumstances under which health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare benefit plan" covered by ERISA. 74 Fed. Reg. 64,276 (2009).

The Secretary of Labor has broad authority to prescribe such regulations as she finds "necessary or appropriate" to carry out the provisions of Title I of ERISA. 29 U.S.C. 1135. The Secretary's authority includes the

power to promulgate regulations defining what constitutes a "plan" within the meaning of Title I. See *Massachusetts* v. *Morash*, 490 U.S. 107, 116-117 (1989). The Secretary's reasonable interpretation of what constitutes an ERISA-covered "plan" is entitled to *Chevron* deference. See *id.* at 116. Therefore, had the Secretary promulgated a regulation clarifying whether and when employers' coverage under local programs like the HCSO does or does not entail creation of ERISA plans, that regulation would have been entitled to *Chevron* deference and could have altered the preemption analysis in this case.

The Department of Labor has, however, decided not to proceed with a proposed regulation at this time because of the recent passage of comprehensive federal health care legislation. See PPACA, Pub. L. No. 111-148, 124 Stat. 119; HCERA, Pub. L. No. 111-152, 124 Stat. 1029. As discussed in more detail below (see pp. 14-17, *infra*), the federal legislation has significantly changed the legal landscape governing health care spending requirements. In particular, the legislation includes provisions designed to encourage the provision and availability of health insurance that reduce substantially the likelihood that state and local governments will choose to enact new employer spending requirements like those contained in San Francisco's HCSO. The federal legislation therefore significantly reduces the importance of the question whether and when such requirements are preempted by ERISA. See pp. 14-15, *infra*. In addition, it is unclear whether the new federal requirements may have independent preemption consequences for local legislation or may affect the preemption analysis under ERISA. See pp. 15-17, *infra*.

For these reasons, in light of the new federal legislation, the Department of Labor has concluded that, at present, it would be premature to proceed with regulatory action. In the unlikely event that additional state or local governments choose to enact health care spending requirements like the HCSO, the Department might reconsider whether the preemption issue has sufficient ongoing significance to warrant administrative action to address it.

2. The preemption issue does not warrant this Court's review at this time for the same reasons that the Department of Labor has determined not to take regulatory action on the issue at this time.

First, the new federal health care legislation contains numerous provisions designed to promote broader access to health care coverage. Those provisions include an employer shared responsibility provision that imposes assessments on employers with 50 or more full-time equivalent employees that do not provide health insurance to their employees if any full-time employee receives a premium tax credit in new health insurance exchanges. See PPACA § 1513, as amended by HCERA § 1003. The legislation also includes a requirement that non-exempted individuals maintain a minimum level of health insurance or pay a penalty. See PPACA § 1501, as amended by HCERA § 1002. And the legislation provides for automatic enrollment of employees in group health plans offered by large employers, PPACA § 1511, and contains several other provisions designed to make health care coverage more affordable and available, *e.g.*, *id.* § 1401, as amended by HCERA § 1001 (premium assistance tax credits); PPACA § 1402, as amended by HCERA § 1001 (reduced cost-sharing); PPACA § 1421

(small business tax credits); and *id.* § 1311 (state-based insurance exchanges).

Many of the new provisions will be phased in over several years, and three different federal agencies—the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor—will be promulgating regulations implementing the provisions. The full contours and effects of many aspects of the new federal framework therefore remain to be fleshed out. Nonetheless, although the new provisions accommodate state authority over regulation of health insurance, they will almost certainly significantly increase health care coverage. They therefore make it much less likely that States and localities will choose to adopt their own health care programs. Accordingly, the federal health care legislation reduces substantially the ongoing importance of the question whether ERISA preempts state and local health care programs like the HCSO.

In addition, unresolved issues about the preemptive force of the new federal legislation may affect the question whether local health care programs like the HCSO are preempted by federal law. The new legislation contemplates a significant role for the States in promoting the availability of health care coverage. For example, the States are authorized to create and administer exchanges for the purchase of health insurance by individuals and employers. The States have substantial flexibility in the operation of those exchanges and the enforcement of related requirements, including the ability to obtain waivers that authorize the establishment of alternative programs. See PPACA §§ 1311-1333. In light of the significant role anticipated for the States, the legislation includes a provision saving certain state

laws from preemption by the newly enacted federal provisions. See *id.* § 1321(d) ("Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."). At present, however, the savings provision has not been interpreted by any Department or court. For example, the responsible federal Departments and the courts have not addressed whether the PPACA's savings provision applies to laws enacted by state subdivisions, such as the HCSO, or only to laws enacted by the States themselves. Compare *id.* § 1034(d) (defining "State," for purposes of the federal health care legislation, to mean "each of the 50 States and the District of Columbia") with 29 U.S.C. 1144(e)(2) (defining "State," for purposes of ERISA, to include "any political subdivisions thereof, or any agency or instrumentality of either"); but see *Wisconsin Pub. Intervenor* v. *Mortier*, 501 U.S. 597, 606-608 (1991) (interpreting the term "State" in the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), 7 U.S.C. 136 *et seq.*, to include local governments, even though FIFRA's definition does not expressly include political subdivisions).

If local health care programs like the HCSO were somehow independently preempted by the new health care legislation, that would further reduce the importance of the question whether such laws would otherwise be preempted by ERISA. If, on the other hand, local health care programs were saved from preemption under the new health care legislation, that consequence could, in turn, alter the analysis of whether those programs would be preempted by ERISA, perhaps depending on the relationship between the local programs and the implementation of the new legislation. As a general matter, a savings provision, such as Section 1321(d) of

the PPACA, that shields state (or local) laws from preemption by only one federal statute has no effect on preemption by other federal statutes. But, unlike most other federal statutes, ERISA expressly provides that it shall not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." 29 U.S.C. 1144(d). When state or local laws are integral to the operation of a federal law other than ERISA, Section 1144(d)'s prohibition on "impair[ing]" other federal laws may shield those state or local laws from ERISA preemption. See *Shaw*, 463 U.S. at 100-102.

At this early stage, the responsible federal Departments and the courts have not addressed the possible relationship between state or local laws like the HCSO and the new federal legislation—*e.g.*, whether such laws might form the basis for waivers under Section 1332 of the PPACA of provisions concerning the creation of insurance exchanges. There accordingly is not yet a foundation for assessing whether or how ERISA Section 1144(d) could be implicated by the implementation of the new health care legislation. These considerations provide still further reasons why this Court's review of the ERISA preemption issue is not warranted at this time.

3. a. Petitioner contends (Pet. 15-34) that the Court should grant review because the decision below purportedly conflicts with the Fourth Circuit' s decision in *Retail Industry Leaders Ass'n* v. *Fielder*, 475 F.3d 180 (2007). Although some of the reasoning contained in *Fielder* is in tension with reasoning in the decision below, the two cases do not present a direct conflict that warrants this Court's review.

Fielder involved a Maryland law requiring employers with 10,000 or more Maryland employees to spend at least eight percent of their total payrolls on health in-

surance costs for their employees or to pay the amount that their spending falls short to the State. The law was nominally of general application, but it covered only Wal-Mart Stores, Inc., and it was designed to force Wal-Mart to increase the health insurance benefits that it provided under an ERISA plan. *Fielder*, 475 F.3d at 183. The Fourth Circuit held that the Maryland law was preempted by ERISA because "the only rational choice employers" had to comply with the law was "to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold." *Id.* at 193. Although employers theoretically had the alternative of paying money to the State, the court concluded that no rational employer would select that option because the employer and its employees would receive nothing in return. *Ibid.*

As the court below explained, unlike the state-payment option under the Maryland law, the HCSO's city-payment option is a realistic alternative for employers because it offers them something in return for their payments—health care benefits for their employees. Pet. App. 38a-40a. Indeed, almost 900 employers had selected the city-payment option at the time of the district court's summary judgment ruling. See Br. in Opp. App. 33. The court below did not dispute that, if the city-payment option itself effectively required creation of ERISA plans by participating employers, the HCSO, like the Maryland law, would be preempted. See Pet. App. 15a. But the court concluded that the city-payment option does not entail creation of an ERISA plan. *Id.* at 15a-26a. That assessment of the operation of the HCSO does not itself give rise to any conflict with the Fourth Circuit's decision in *Fielder*, which did not suggest that an employer's election of the state-payment option under the Maryland statute would entail creation of an

ERISA plan. And, because that assessment of the HCSO was the underlying premise of the court of appeals' ultimate decision in this case, its preemption ruling does not conflict with *Fielder*.

The Fourth Circuit also stated in *Fielder* that, even assuming that an employer could comply with the Maryland law without creating an ERISA plan (such as by providing on-site medical clinics or health savings accounts), the law would still have an impermissible "connection with" ERISA plans because it would interfere with "uniform nationwide" plan administration by requiring employers "to keep an eye on conflicting state and local minimum spending requirements and adjust [their] healthcare spending accordingly." 475 F.3d at 196-197. That reasoning could also be applied to the HCSO, and it is therefore in tension with the decision below, as the Department of Labor pointed out in its brief supporting rehearing en banc in the court of appeals. Pet. App. 80a-81a. But the Fourth Circuit's view that the Maryland law would disrupt uniformity of plan administration also reflected in part that court's conclusion that the state-payment option was not a realistic alternative for Wal-Mart, the one covered employer. That conclusion does not apply to the HCSO, which the court below also concluded does not impose burdens significantly different from those necessary to comply with tax laws of various state and local jurisdictions. *Id.* at 19a. It is therefore not clear that the Fourth Circuit would find that a law such as the HCSO poses the same threat to uniformity of plan administration as the Maryland law and further find such a law preempted on that ground alone.

In any event, this Court "reviews judgments, not statements in opinions," *Black* v. *Cutter Labs.*, 351 U.S.

292, 297 (1956), and the judgment in *Fielder* does not conflict with the judgment below because, as interpreted, the laws at issue in the two cases have fundamental differences. As understood by the Fourth Circuit, the Maryland law in *Fielder* effectively forced the single affected employer to alter its ERISA plan; but, as understood by the court below, the HCSO does not require employers to alter or create any ERISA plans.

b. Contrary to petitioner's contention, the decision below does not directly conflict with this Court's ERISA decisions. Unlike the law that the Court held preempted in *Shaw*, the HCSO does not require employers to provide specific benefits. Compare *Shaw*, 463 U.S. at 97 (holding New York law preempted because it "require[d] employers to pay employees specific benefits"), with Pet. App. 29a (noting that, unlike the law in *Shaw*, the HCSO does not "require any employer to provide specific benefits through an existing ERISA plan or other health plan"). Similarly, this Court concluded that the law in *Egelhoff* was preempted because it offered no method of compliance that did not require a change in the way an ERISA plan was operated or written. 532 U.S. at 151. In this case, in contrast, the court of appeals concluded that employers can comply with the HCSO without creating or amending an ERISA plan. See Pet. App. 29a-30a.

Finally, the decision below does not directly conflict with either *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990), or *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125 (1992). The law that this Court held preempted in *Ingersoll-Rand Co.* was "premised on[] the existence of [an ERISA] plan" because, in order to prevail on a claim under the law, the plaintiff had to establish "that an ERISA plan exist-

[ed]." 498 U.S. at 140. Here, in contrast, under the view of the court of appeals that the city-payment option does not require employers to create ERISA plans, an employer can comply with the HCSO even if it has no ERISA plans. Pet. App. 33a. The HCSO also differs from the local ordinance that this Court held preempted in *Greater Washington Board of Trade* because, under that ordinance, employers were required to provide workers' compensation benefits at the same level provided by their existing ERISA plans. See 506 U.S. at 130. Under the HCSO, an employer's payment obligation is based on the hours worked by covered employees. Although an employer may receive a credit against its obligation for other health-related expenditures, including those made under an ERISA plan, an employer may also receive credit for payments made to the City (which, under the court of appeals' view, do not involve an ERISA plan). Pet. App. 34a-35a.

c. In any event, even had a square conflict materialized in the courts of appeals, review by this Court would not be warranted. As discussed above, the intervening enactment of comprehensive federal health care legislation has dramatically changed the landscape governing payment for health care, substantially reducing the importance of the question whether ERISA preempts state or local requirements and also giving rise to additional legal issues that have not been addressed by the federal Departments responsible for implementing the new legislation or by the courts. Accordingly, this Court's review of the ERISA preemption issue is not warranted at this time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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